Washington State Health Care Authority
Public Employees Benefits Board

Request for Review/Notice of Appeal

- Type or print clearly in black ink.
- Keep a copy of the form for your records.

If you are:	You must:
A state agency or higher-education employee, or the dependent of one, seeking a review of a decision or action by your employer or the Public Employees Benefits Board (PEBB) Program concerning eligibility, enrollment for benefits, or premium payments.	Submit this form to your employer or the PEBB Program (whichever made the decision you are appealing) **no later than 30 days** from the date of the decision or action you are appealing.
A retiree, survivor, COBRA member, Leave Without Pay member, PEBB Extension of Coverage member, or the dependent of one, seeking a review of a decision or action by the PEBB Program	Submit this form to the PEBB Program **no later than 60 days** from the date of the PEBB Program's decision or action.
An employer group or K-12 school district employee, or the dependent of one, with an appeal concerning:	
• PEBB eligibility or enrollment	Contact your employer to request information on how to appeal their decision or action.
• Eligibility, enrollment, or premium payment determinations for life or long-term disability insurance	Submit this form to the PEBB Program **no later than 30 days** from the date of the decision or action you are appealing.
A retiree or the employee of any of the above employers seeking a review of a decision or action by a health plan or insurance carrier about a claim or benefit (such as a dispute about a course of treatment or billing)	Contact the health plan or insurance carrier to request information on how to appeal their decision or action.

Section 1: Subscriber Information

Subscriber type (select one): ❑ Employee ❑ Retiree ❑ Survivor ❑ Applicant (not enrolled in PEBB coverage)
❑ COBRA, Leave Without Pay, or PEBB Extension of Coverage member

Last name	First name	Middle initial	Social security number	
Street address / Apt./unit number		City	State	ZIP Code
Mailing address (if different from above) / Apt./unit number		City	State	ZIP Code
Email address		Work phone number ( )	Home phone number ( )	

Dependent Information *(if appeal concerns a dependent)*

Last name	First name	Middle initial	Social security number

(continued)

Section 2: Describe Your Request for Review/Appeal

What decision or action do you want reviewed?

Why do you disagree with the decision or action taken? Please give a detailed description of your situation and attach supporting documentation.

What was the date of the decision or action made by the employing agency or PEBB Program?

What would you like done about the decision or action?

Is there any additional information you would like to include? *(Attach additional pages as necessary.)*

❑ I have attached additional documents. (For example, forms or correspondence between me and my employer or the PEBB Program.)

Section 3: Representative Information *(Complete this section if you have someone else to represent you on this issue.)*

Last name	First name	Middle initial	Phone number ( )	
Street address	Apt./unit number	City	State	ZIP Code

Section 4: Signature

Sign and date this section, and keep a copy of this form for your records. Submit the form within the timeline shown in the table on page 1.

By signing this form, I declare that the information I have provided is true, complete, and correct.

Signature _____ **Date** _____

If you are a state agency or higher-education employee, or the dependent of one, and wish to request a review of your employer's decision:	**If you wish to appeal a PEBB Program decision:**
• Submit this form to the employer's personnel, payroll, or benefits office. • Your employer will complete Section 5 and return a copy of this form to you. • If you disagree with your employer's decision in Section 5, you may appeal by completing Section 6.	Read and sign Section 4. Submit this completed form to: **Health Care Authority** **PEBB Appeals** **P.O. Box 42699** **Olympia, WA 98504-2699**

(continued)

To be completed by the employer

Section 5: Employer Decision Notice

Employers: *As described in WAC 182-16-030, you have received a request to review a decision by your agency about eligibility for or enrollment in PEBB coverage by the employee or dependent listed in Section 1. Complete this section after sections 1-4 are completed; see WAC 182-16-030 and 182-16-040 for guidance. After completing this section, return a copy to the employee no later than 30 days after receiving this form, also return a copy to your agency administrator (or designee) and then attach it to a FUZE email and send it to PEBB Appeals for our records. You can log in to FUZE email at* ***www.hca.wa.gov/perspay****.*

Date of employer's initial decision or action _____

Date the employer received the employee's request for review _____

Did you receive this request for review within 30 days of the agency's initial decision or action? ❑ Yes ❑ No

Agency number	Subagency number	Agency contact	Agency contact email	Agency contact's phone number ( )

Employer Response to the Request for Review

❑ This appeal relates to a PEBB decision (e.g. denied certification of an extended dependent or dependent with a disability). The employer will sign below, forward to the PEBB Appeals Committee for action, and provide a copy to the employee.

❑ The employer did not receive the employee's request within 30 days of the initial decision or action. The employer cannot consider this request.

❑ The employer stands by its original decision or action. No employer error or delay caused a wrong decision or action. The employee has the right to appeal this decision by completing Section 6 and submitting this form to the PEBB Appeals Committee **no later than 30 days** from the employer's review decision date.

❑ The employer agrees that a wrong decision or action occurred due to (pick one): ❑ Agency delay ❑ Agency error

Please explain the delay or error:

_____

_____

Medical and/or dental eligibility or enrollment:
The agency will now take the following action to correct the decision or action caused by delay or error:

_____

_____

Life or long-term disability eligibility, enrollment, premium issues:
The agency recommends the following action to correct the decision or action caused by delay or error (forward recommendation to the PEBB Program for a final determination):

_____

_____

Reviewer's name (print or type)	Reviewer's phone number ( )

Reviewer's signature _____ **Review decision date** _____

Section 6: Employee Notice of Appeal to PEBB

Employees: Do not complete this section until after you receive a copy of this form back from your employer with Section 5 completed. If you wish to appeal your employer's decision in Section 5, sign and date this section and submit this form to the PEBB Program, along with a statement that explains why you disagree with the employer's decision.

You must submit this form **no later than 30 days** from the review decision date in Section 5 to Health Care Authority, PEBB Appeals, P.O. Box 42699, Olympia, WA 98504-2699.

By signing this form, I declare that the information I have provided is true, complete, and correct.

Signature _____ **Date** _____